01/23/2017

MONTANA LABORATORY SENTINEL

Updates from the MT Laboratory Services Bureau

800-821-7284

www.lab.hhs.mt.gov

Save the Date!

APHL is hosting its annual CLSI AST Update on February 1st and 2nd. This year you will learn about the changes in M100S 27th edition tables ("The CLSI AST Tables") and practical tips to help you easily comprehend and implement the new recommendations into your protocols; hear highlights for 2017, to include additional suggestions for testing colistin/polymyxin B and poorly growing *Staphylococcus aureus*; *and* receive a self-study tool, designed to reinforce materials presented during the webinar. MTPHL will be viewing the CLSI 2017 AST Update on **Thursday, February 2nd from 1:00-2:30** in Conference Room C209 of the Cogswell Building, 1400 E Broadway in Helena. If you are in the area, please feel free to join us. If you would like to view the webinar in your facility, please click on one of the registration links: Click here for online registration February 1, 2017 or Click here for online registration February 2, 2017

Post–Vaccination Serologic Testing (PVST) for Infants Born to HBV-infected Women

Post–Vaccination Serologic Testing (PVST) helps identify infants born to hepatitis B virus (HBV) - infected mothers who do not have an adequate immune response to an initial hepatitis B vaccine series and might require additional vaccinations. PVST also enables early identification of HBV- infected infants. The Centers for Disease Control and Prevention (CDC) has recently recommended that infants born to HBV-infected mothers receive PVST consisting of a hepatitis B surface antigen (HBsAg) and an antibody to hepatitis B surface antigen (anti-HBs) after completion of the hepatitis B vaccines series. The recommended timing of these tests is at age 9-12 months or 1–2 months after the final dose of the vaccine series, if the series is delayed.

CDC estimates that 35% of babies born to HBV infected mothers may not receive recommended PVST after completion of the Hepatitis B vaccine series. Often, providers order (1) either an HBsAg or an anti-HBs, but not both or (2) a hepatitis panel that does not include the recommended tests. As part of the initiative to improve PVST of babies born to HBV infected women, CDC recommends that laboratories create a PSVT panel for infants born to HBV infected women. Offering providers a PVST panel will help to identify infants with HBV infection or an inadequate response to the vaccine series. See the attached PDF or follow this link for more details on this public health initiative. PVST Panels for Infants Born to HBV-infected Women Information (https://www.cdc.gov/hepatitis/hbv/pvst.htm)

Carbapenem- Resistant Enterobacteriaceae Surveillance

The emergence and dissemination of carbapenem resistance among Enterobacteriaceae in the United States represents a serious threat to public health. These organisms cause infections that are associated with high mortality rates and they have the potential to spread widely. Decreasing the impact of these organisms will require a coordinated effort involving all stakeholders including healthcare facilities and providers, public health, and industry. The Montana Public Health Laboratory (MTPHL) was funded through CDC's Epidemiology and Laboratory Capacity Cooperative (ELC) agreement to collect, confirm, and characterize carbapenem-resistant Enterobacteriaceae (CRE) and *Pseudomonas aeruginosa* (CRPA) isolates. These activities help identify isolates that produce a carbapenemase and classify the kind of carbapenemase present. Transport and testing will be fee waived upon consult and approval.

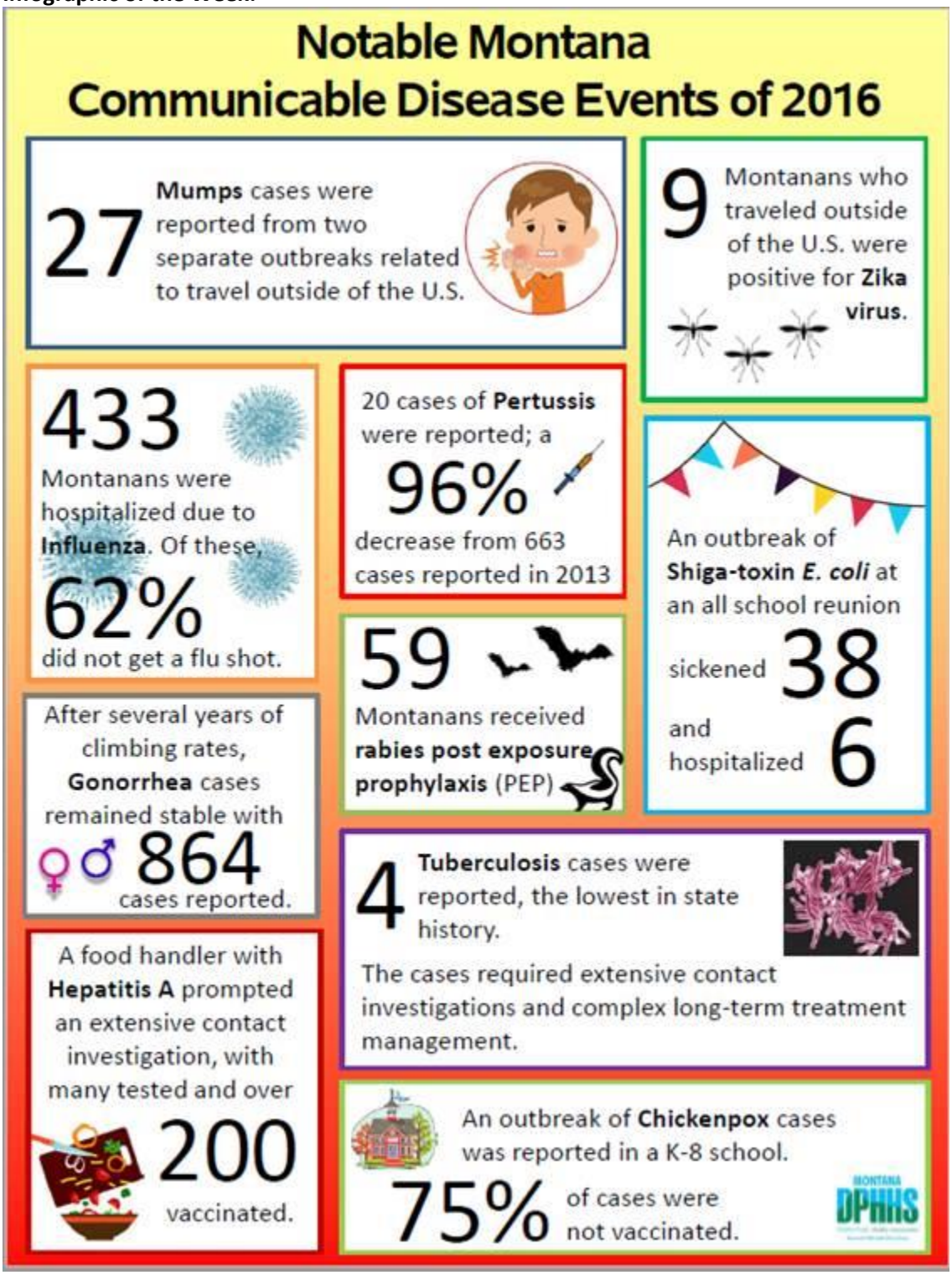
Isolates of interest include: *Escherichia coli*, *Klebsiella oxytoca*, *Klebsiella pneumoniae*, and *Enterobacter* spp. that are resistant to imipenem, meropenem, doripenem, or ertapenem by standard susceptibility testing methods (i.e., minimum inhibitory concentrations of ≥4 µg/mL for doripenem, imipenem or meropenem or ≥2 µg/mL for ertapenem) and include all *P. aeruginosa* isolates that are resistant to imipenem, meropenem, or doripenem by standard susceptibility testing methods (i.e., minimum inhibitory concentrations of ≥8 µg/mL).

For more information please contact the Montana Public Health Laboratory at 1-800-821-7284

Montana Communicable Disease Weekly Update

Release date: 01/20/2017

Infographic of the Week:



To download and print a high resolution pdf version of MTDPHHS infographics, or to view the archive of weekly infographics, please visit the [CDEpi infographics page].

DISEASE INFORMATION

Summary – MMWR Week 1 – Ending 1/14/17 Preliminary disease reports received by DPHHS for the reporting period January 8–14, 2017 included the following:

- **General Communicable Diseases:** Elevated blood lead (2), Legionellosis (1)
- **Enteric Diseases:** Campylobacteriosis (6), Salmonellosis (2)
- **Vaccine Preventable Diseases:** *Haemophilus influenzae* (1), Influenza hospitalization[†](42), *Streptococcus pneumoniae* (1), Varicella [chickenpox](2)
- **STD/HIV:** Chlamydia (59), Gonorrhea (10), HIV[*](0)
- **Hepatitis:** Hepatitis C, chronic (16)
- **Zoonotic diseases:** Lyme Disease[‡] (1)
- **Animal Rabies:** (0)

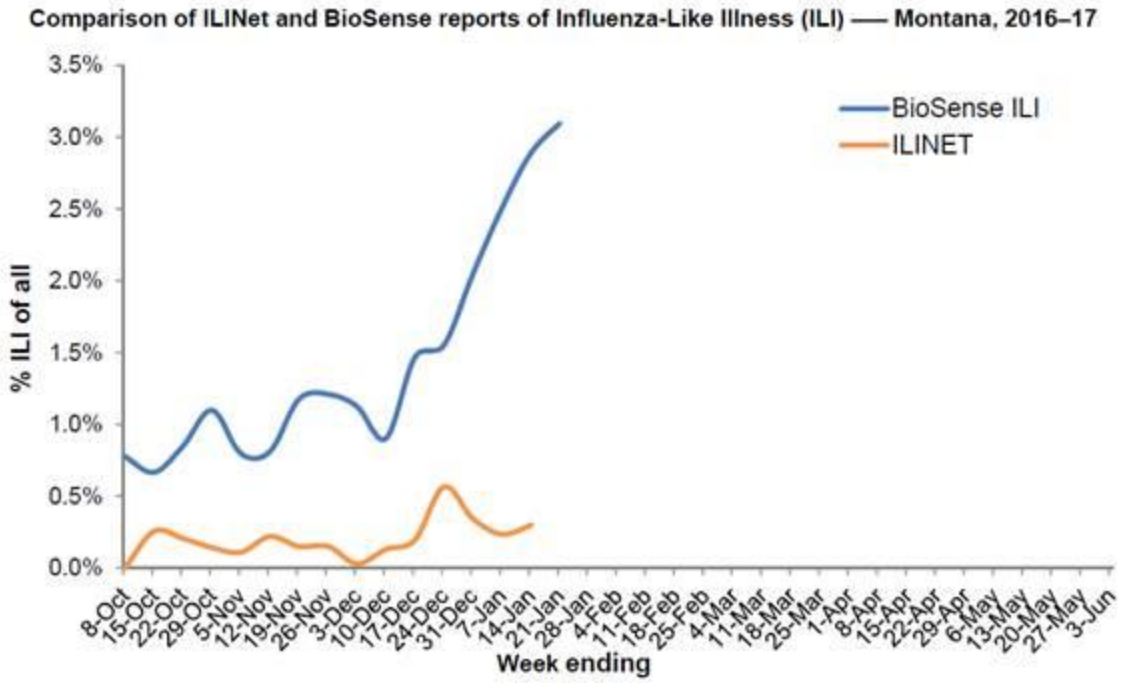
[*] *A case is included if a new confirmatory test or report was received by DPHHS. Cases include both persons who were newly diagnosed and persons newly reported in Montana who may have been diagnosed in another state or country.*
[†] *Influenza hospitalizations are presented by the MMWR week that the case was reported into MIDIS. For additional information on influenza, please refer to the weekly Montana Influenza Summary.*
[‡] *Case is acquired outside of Montana*
NOTE: The attached report has multiple pages reflecting the following information: (1) cases for the past reporting week; (2) communicable diseases YTD; (3) clusters and outbreaks; and (4) a quarterly HIV/STD summary.

HOT TOPICS

Norovirus Outbreaks: In 2017, five acute gastroenteritis outbreaks have already been reported across the state. When testing was done, norovirus was the confirmed agent. Outbreak activity remains high during January, so please be alert for GI illnesses in your community, make partners aware and share resources how to control GI outbreaks in various settings, if applicable. More resources and information are available on the DPHHS website. Outbreak reporting forms are available on SharePoint.

Influenza: Influenza activity remained at widespread for the last reporting week. Season to date, 204 hospitalizations have been reported, the majority of which were aged 65 years and older. Influenza like illness reported as chief complaint in emergency rooms across the state through the syndromic surveillance system have increased over the last few weeks with over 3% of ER visits indicating influenza like illness. Nationally, the proportion of outpatient visits for influenza-like illness (ILI) utilizing the ILI sentinel provider system was 3.3%, which is above the national baseline of 2.2%.

Syndromic Surveillance vs. ILI: BioSense is the syndromic surveillance system in place for Montana that captures approximately 80% of emergency room (ER) visits across the state. ER visits associated with influenza like illness are compared below with the ILINet data for the 2016–17 season in Montana.



MIDIS users -- Please continue to report your cases and flu hospitalizations into MIDIS as you receive them. When you are reporting influenza hospitalizations in MIDIS, please remember to include the following information:

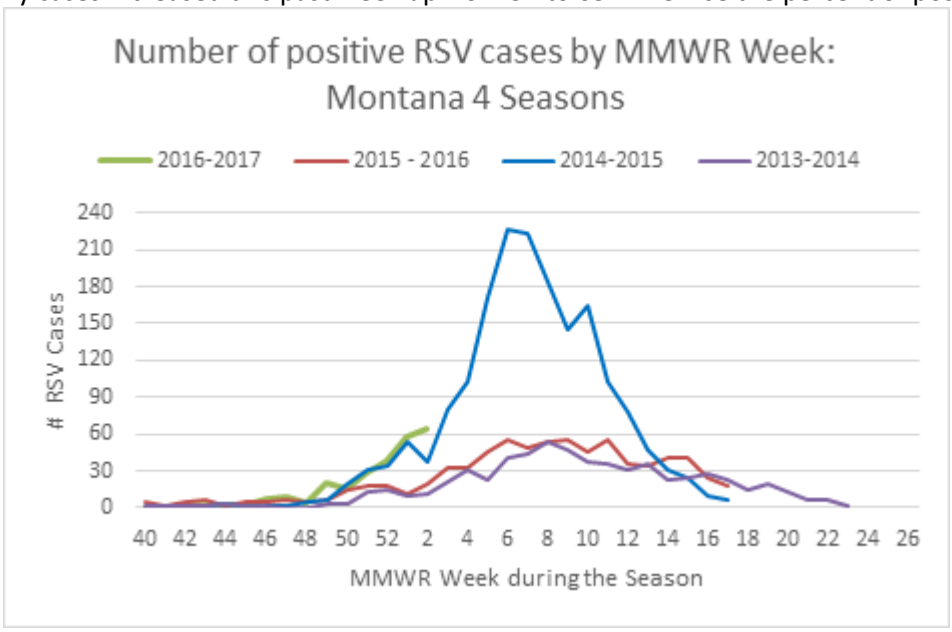
- Date of hospital admission

Please include the following in the investigation comments:

- Type of influenza diagnosed
- Seasonal influenza vaccination status
- Any comorbidities present at admission

The Montana Influenza Summary is updated every Friday and can be found here: Montana Influenza Summary . You can view the latest Weekly U.S Influenza Surveillance Report from CDC here: http://www.cdc.gov/flu/weekly/

RSV: The number of weekly cases increased this past week up from 57 to 65. Likewise the percent of positive cases increased slightly to 22%.



INFORMATION/ANNOUNCEMENTS

Rabies Training 2017 (*Date Change*): CDEpi is preparing a regional training addressing rabies issues and response to potential exposures for local health jurisdictions. The scope of this training will educate public health professionals regarding the investigation and management of potential rabies exposures and provide resources necessary to work with key partners. This activity will be submitted to Montana Nurses Association for approval to award contact hours.

Please be advised of the **tentative date changes** due to room availability. An email with a registration link will be send once meeting dates and locations have been finalized, so you can make travel arrangements.

The current locations and dates are Missoula (3/23/2017), Glasgow* (**4/4/2017**) and Billings (**4/5/2017**) from 10am until 3pm. Lunch will be served at the day of the conference. There is no charge to attend the training. However, rooms and travel are the responsibility of the attendee.

*depending on attendance

Transition to STD case entry in MIDIS (Update): The transition of STD data entry into MIDIS at the local level underway. Nine high-incidence jurisdictions have completed training and testing and have or will begin entering STD case records into the production system. Additional trainings will be conducted in batches of four or five counties.

DPHHS has prioritized jurisdictions with higher caseloads for transition to the new system. Staff will be contacting other jurisdictions regarding roll-out to other areas as we assess use by the pilot counties and our training resources. Instruction, practice of demo cases data entry and subsequent feedback should generally take less than two weeks, depending on workload of the local health department staff. Training consists of a 90-minute webinar, followed by practice data entry of three cases into the MIDIS test system.

THANK YOU FOR YOUR HELP! We realize transitioning from state-level STD entry to local level entry may increase your local workload. However, we hope the overall benefit to our reporting systems and local use of the data outweigh the additional work. Thank you all for your support of this effort.

Q&A CORNER

(Clarification): Last week, the Q and A addressed the new federal rule requiring that long term care facilities designate an infection preventionist and have an infection prevention and control program (IPCP) that implements "a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services …" To clarify, long term care facilities are required to begin implementation of the IPCP, but will not have to designate an infection preventionist until phase III of the rollout November 28th, 2019. We are finding though, that in many cases long term care facilities have already designated individuals to address reporting issues both internally and externally. For more information on the new federal rule, link to Federal Rule effective 10/04/2016 Reform of Requirements for Long-Term Care Facilities.

Q: ***I am uncertain what disease forms I need to submit to DPHHS CDEpi. Can you help?***

A: Case Report Forms for a variety of reportable conditions are being faxed or emailed to us that are not needed internally here at CDEpi. The attached reporting poster lists the forms that should or ***should not*** be faxed to us.

Local Health Jurisdictions should also take the opportunity to review those Case Report Forms that they have on-hand. ***Many jurisdictions are still sending long outdated forms some of which are over ten years old.*** Please go to the CDEpi SharePoint® pages for the current reporting forms.

Q: ***I have a positive influenza result in my MIDIS queue. What do I do with it?***

A: When you receive an influenza PCR result in your MIDIS queue, you will need to check in with the provider's office to determine if the individual was hospitalized due to influenza. If yes, then you will need to create an investigation for this

patient in MIDIS (choose “influenza, hospitalization from the drop-down menu). This result should also be included in your weekly aggregate case count. If the individual was not hospitalized, then you should include it in your weekly case count and can mark the lab as reviewed.

Communicable Disease Epidemiology Suggestion Box:

To submit a question or comment to the Communicable Disease Epidemiology Section, please click on the suggestion box to access our online form.

24/7 AVAILABILITY

The Communicable Disease Epidemiology (CDEpi) Section is available 24 hours a day, 7 days a week, 365 days a year, to assist local health jurisdictions. Local providers should call, including after normal business hours, their local health jurisdiction. The CDEpi 24-hour line is available as a back-up to the local health jurisdiction’s 24-hour line. If you need CDEpi assistance, please call 406.444.0273. Phone calls to this number outside of normal business hours will be answered by the answering service. The answering service will immediately forward the message to CDEpi, and we will respond as quickly as possible.

Local health jurisdictions, please ensure that your local providers have your 24/7/365 contact information. And please inform CDEpi or the Public Health Emergency Preparedness Program of updates to your required 24/7 contact information.

This update is produced by the Montana Communicable Disease Epidemiology Section. Questions regarding its content should be directed to 406.444.0273 (24/7/365). For more information: *http://dphhs.mt.gov/publichealth/cdepi*